Unannounced Care Inspection Report
21 October 2020

Valley Nursing Home

Type of Service: Nursing Home
Address: 8 Tullybroom Road,Clogher,BT76 0UW
Tel No: 028 855 480 48
Inspectors: Jane Laird, Laura O'Hanlon and Phil Cunningham

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the servicefrom their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes2015.

1.0 What we look for

2.0 Profile of service

This is a nursing home which is registered to provide nursing care and residential care for up to 96 persons. Patients' bedrooms are located within two buildings. The 'Main House' comprises three distinct units: one unit providing care for people requiring frail elderly nursing care, one unit for people living with dementia and one unit for people living with a brain injury. The adjacent building (Tullybroom House) provides care for people living with dementia.

3.0 Service details

Organisation/Registered Provider: Healthcare Ireland Belfast Ltd **Responsible Individual:** Amanda Celine Mitchell	**Registered Manager and date registered:** Lorraine Margaret Cozma – 30 June 2020
Person in charge at the time of inspection: Lorraine Margaret Cozma	**Number of registered places:** 96 A maximum number of 58 patients in category NH-DE, in addition 2 persons may receive care on a day basis only in Tullybroom House and 2 persons who do not require bath/shower facilities may receive care on a day basis only in the Dementia Unit (Main House). There shall be a maximum of 2 named patients receiving residential care in category RC-DE and 1 named patient receiving residential care in category RC-A.
Categories of care: Nursing Home (NH) DE – Dementia I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** Tullybroom House – 17 Amadeus – 21 Lane suite – 0 Valley suite – 12 50 patients in Total

4.0 Inspection summary

An unannounced inspection took place on 21 October 2020 from 09.45 to 20.15 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in homes. In response to information received by RQIA regarding concerns about this home and recent enforcement history; a decision was made to undertake a care and premises inspection.

In addition RQIA had been made aware that thecurrent registered provider, Ms Amanda Mitchell Healthcare Ireland Belfast Ltd.(HCI) had been given notice by the previous registered provider

and owner of the premises, Mr Paul Warren-Gray MPS Ltd., that their management contact to operate the home had been terminated and would end on 12 December 2020. RQIA were not aware that this management arrangement had continued beyond the point at which HCI became registered in June 2020, and wanted an assurance that the governance and management arrangements within the home were robust.

The concerns were in relation to the following:

- management of COVID-19 guidance specific to delegation of staff and isolation measures
- availability of incontinence pads, wipes and hand paper towels
- mandatory training specific to moving and handling
- lack of stimulation and availability of meaningful activities
- damage to the internal/external roof in one of the dementia units
- staffing levels
- lack of communication from management regarding updates about the home.

The following areas were examined during the inspection:

- management, leadership and governance arrangements
- staffing arrangements
- infection prevention and control (IPC) measures
- the home's environment
- care delivery
- care records.

Significant concerns were identified with regard to: the internal environment; infection prevention and control (IPC); fire safety practices; maintenance health and safety checks; Control of Substances Hazardous to Health (COSHH) compliance; care delivery; care records; staff interaction with patients and managerial oversight and governance. In addition, the above concerns were partially substantiated and are discussed further within the report.

Following the inspection, a meeting was held on 28 October 2020 in RQIA with the intention of cancelling the registration of Amanda Mitchell, the responsible individual (Healthcare Ireland Belfast Ltd), in respect of the Valley Nursing Home under Article 18 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, (the 2003 Order).

The meeting via video conference was attended by Amanda Mitchell, responsible individual, Gilbert Yates, director of Healthcare Ireland Belfast Ltd, Lorraine Cozma, manager and Mary Stevenson, regional manager. RQIA was advised during the meeting of some actions which had been taken immediately and others which were being proposed in relation to the deficits highlighted during this inspection. However, during the meeting RQIA did not receive the necessary assurance required. RQIA decided to issue a Notice of Proposal (NOP) to cancel the Registration.

RQIA informed relevant stakeholders including the Trusts, Health and Social Care Board and the Department of Health following the inspection and continue to liaise with them during this process.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*17	*8

*The total number of areas for improvement includes two regulations and two standards which have been stated for a second time and one regulation and one standard which have been stated for a third and final time.

Details of the Quality Improvement Plan (QIP) were discussed with Lorraine Margaret Cozma, manager and Mary Stevenson, regional manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from this inspection.

The enforcement policies and procedures are available on the RQIA website. https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/ Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care and premises inspection
- the registration status of the home
- written and verbal communication received since the previous care and premises inspection
- the previous care and premises inspection report.

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

The following records were examined during the inspection:

- duty rota for all staff from 12 October 2020 to 19 October 2020
- staff training records
- two staff recruitment and induction files
- nine patient care records
- two patient repositioning charts
- a sample of governance audits/records
- complaints record
- compliments received
- maintenance records
- a sample of monthly monitoring reports from July 2020.

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previousinspection

The most recent inspection of the home was an announced care inspection undertaken on 9 June 2020.

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 21(1) (b)(c)

Stated: Second time</td><td>The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files prior to commencing employment. This relates specifically to ensuring that health checks for staff are completed and that gaps in previous employment are effectively reviewed.</td><td rowspan="2">Partially met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of a sample of recruitment files evidenced that a health check had not been obtained for an identified employee.

This area for improvement has been partially met and has been stated for a third and final time.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Regulation 14 (2) (a) and (c)

Stated: First time</td><td>The registered person shall ensure that food thickening agents are stored securely.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Observation of the environment evidenced that food thickening agents had not been stored securely.

This area for improvement has not been met and has been stated for a second time.</td></tr>
</table>

Area for improvement 3 **Ref:** Regulation 27 (4) **Stated:** First time	The registered person shall ensure the fire doors in the Amadeus Unit are ableto close properly and that a home wide system to monitor this is implemented with the necessary records maintained.	**Not met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that a number of fire doors were not maintained to close properly. This area for improvement has not been met and has been stated for a second time.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 18 **Stated:** Second time	The registered person shall ensure that the level, nature and type of any restraint is proportionate to the risk it is attempting to address and that relevant documentation is maintained including evidence of consultation with the patient (where appropriate), their next of kin and care manager. This is with specific reference to the locking of bedroom doors within the identified unit of the home.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that this area for improvement had been met.	
Area for improvement 2 **Ref**: Standard 18 **Stated:** Second time	The registered person shall ensure that effective arrangements are in place to ensure that person centred activities are provided to patients in the absence of activities staff being on duty.	**Not met**
	Action taken as confirmed during the inspection: Observation of the interactions between staff and patients throughout the inspection evidenced that there was no activities being carried out in the absence of the activities staff. This area for improvement has not been met and has been stated for a third and final time.	
Area for improvement 3	The registered person shall ensure that staffing arrangements in the home are sufficient to meet	**Met**

Ref: Standard 41 **Stated:** First time	the assessed needs of the patients at all times.	
	Action taken as confirmed during the inspection: On discussion with staff and review of the staff duty rota the planned staffing levels had been adhered to on most occasions.	
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that a system of monitoring patients who cannot use the nurse call system is implemented to ensure that all patients' needs are being met.	**Met**
	Action taken as confirmed during the inspection: Review of individual patient bedrooms and governance records evidenced that patients either had access to a nurse call system or were reviewed by staff at regular intervals throughout the day.	
Area for improvement 5 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that any patient who requires staff to manage their cigarettes has, within their care record; evidence of/or their representatives as to what the specific arrangements are and the frequency of the review of these arrangements.	**Not met**
	Action taken as confirmed during the inspection: Review of a sample of care records for patients who smoke evidenced that there was no record of a consultation with the patient and/or their representative regarding the management of cigarettes. This area for improvement has not been met and has been stated for a second time.	
Area for improvement 6 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that in the absence of the named nurse care plans and risk assessments are regularly reviewed by a competent person.	**Not met**
	Action taken as confirmed during the inspection: Review of a sample of care records evidenced that a number of care plans and risk assessments had not been updated on a regular basis.	

	This area for improvement has not been met and has been stated for a second time.	
Area for improvement 7 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure: • that where a patient is assessed as requiring a specific hoist that the type of hoist and sling is clearly documented within their care plans and risk assessments • that changes to the frequency of urinary catheter renewal are discussed and agreed with relevant health care professionals and documented within the patients care records.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of care records evidenced that the type of equipment required to carry out specific interventions was clearly documented within the care plan and risk assessment.	

6.2 Inspection findings

6.2.1 Management, leadership and governance arrangements

On arrival to the home the manager advised us of the current COVID-19 outbreak status within the home and that relevant measures were in place as per public health agency (PHA) guidance. Upon entering the home, it was noted that staff only recorded the inspector's temperature at the inspector's request; the manager was reminded of the need to obtain the temperature of all persons entering the home in line with the current COVID-19 guidelinesfor visiting care homes.

During the inspection concerns were identified in relation to the internal environment; infection prevention and control (IPC); fire safety practices; maintenance of health and safety checks; Control of Substances Hazardous to Health (COSHH) compliance; care delivery; care records; staff interaction with patients; managerial oversight and governance. These issues had the potential to impact on the health and safety of the patients, staff and/or visitors.

We reviewed a sample of recruitment files for staff which evidenced that a pre-employment health check had not been obtained for one employee. This was an area for improvement which was identified at previous inspections and has been stated for a third and final time.

Induction records for two employees were not available for review. The manager advised that these records were possibly with the individual employees but was unsure of the exact location of these records. The importance of maintaining such records within the home was discussed with the manager and identified as an area for improvement.

We reviewed a sample of available audits which had been carried out in relation to health and safety, medicines management, care records, hand hygiene and infection prevention and control (IPC). The audits did not effectively identify the deficits which were found during inspection. We further identified that audits were either not signed and/or dated and did not have an agreed timeframe to address the issues which had been identified. This was discussed with the management team and an area for improvement was made.

There was lack of management oversight in relation to the quality/accuracy of care records and an ineffective system for ensuring that care records are reviewed and/or updated by the named nurse. This area for improvement has been stated for a second time.

Despite the high compliance with mandatory training we evidenced poor staff knowledge in relation to fire safety and IPC which had the potential to compromise the health and safety of both patients and staff. These concerns were discussed in detail with management who agreed to monitor staff practice as part of the manager's daily walk around.

The monthly monitoring reports provided to RQIA, by the manager for July, August and September 2020 did capture some of the issues that were identified at this inspection but action plans were not reviewed to assess whether the action had been addressed and were not effective at driving the necessary improvements. This was identified as an area for improvement.

RQIA previously issued seven failure to comply notices to the Valley Nursing Home on 16 July 2019 and on 27 July 2019 and issued a Notice of Proposal to place conditions on the registration of the then Provider, Mr Paul Warren-Gray of MPS Limited. There was a lack of progress to address the identified breaches of regulations and on 27 December 2019, RQIA issued a Notice of Proposal to Cancel the Registration of the then Provider.

On 15 January 2020 RQIA met with the current provider, Healthcare Ireland Belfast Limited, and agreed that they could operate the home under a temporary management contract whilst they prepared to submit an application to register. At this time there was an undertaking from Healthcare Ireland Belfast Limited, to commence a significant programme of works to improve the premises.

An inspection was undertaken on 9 June 2020 and evidenced improvements to care and the overall governance and management arrangements. It was acknowledged that environmental issues had not been fully addressed but RQIA were assured that a refurbishment plan was in place and works would be undertaken. An application was received from Amanda Mitchell as responsible individual for Health Care Ireland, in respect of Valley Nursing home and this was approved by RQIA on 30 June 2020.

During the meeting on the 28 October 2020, RQIA were made aware that the aforementioned management contract had remained in place between Mr Paul Warren-Gray of MPS Limited and Healthcare Ireland Belfast Limited. Contractual arrangements with the Southern Health and Social Care Trust, employment agreements with staff and maintenance repairs of the home continued to be overseen by Mr Paul Warren-Gray of MPS Limited. RQIA had not been made aware of this and were concerned that the responsible individual of Healthcare Ireland Belfast Limited had no control over these matters.RQIA were not assured in relation to the efficacy and tenability of the current arrangements.

RQIA werefurther concerned that there had been a lack of progress in the planned works required and in fact, the premises have deteriorated further. Please refer to Section 6.2.4.

Improvements noted at the inspection on 9 June 2020 in relation to the governance and management arrangements have not been sustained.

6.2.2 Staffing arrangements

Discussion with staff confirmed that they were satisfied with current staffing arrangements. Staff told us they liked working in the home and felt there was good management support. They advised us that due to COVID-19 restrictions they remain within their designated unit to reduce the footfall of staff within the home but that on occasions they are required to work in other areas of the home but never during the same shift.Two members of staff expressed their concern about the attitude of the office staff. This was discussed with the manager to address.

We also sought staff opinion on staffing via the online survey. There were no responses received within the time frame allocated.

The manager confirmed the daily planned staffing levels and that these levels were reviewed regularly to ensure the assessed needs of the patients were met. We were aware of the COVID-19 outbreak within the home and that a number of agency staff were blocked booked to ensure continuity of care. Review of the duty rota and discussion with the manager confirmed that staffing levels had been maintained. Where there were vacant shifts these were covered by agency staff that were block booked to maintain continuity of care and reduce overall footfall during the pandemic. Anumber of other concernswere identified in relation to the maintenance of the staff duty rota. For example, written entries had been inappropriately scored over; the first and/or surnames of staff were missing on a number of occasions; the hours worked by staff and staff designations/roles were not clearly recorded. Given the staff duty rota's lack of clarity, we were unable to determine whether the planned staffing levels had been achieved. This was identified as an area for improvement.

6.2.3 Infection prevention and control (IPC) measures

On discussion with staff they were knowledgeable regarding the symptoms of Covid-19 and how to escalate any changes in a patient's usual presentation to the person in charge. Staff advised that if they themselves felt unwell, they would inform the person in charge and isolate, at home, as per regional guidance and would only return to work if they were symptom free and as per public health agency (PHA) advice. Staff also confirmed that twice daily temperature checks on both patients and staff were being carried out and a review of relevant governance records confirmed that this had been completed.

We found that there was an adequate supply of PPE at the entrance to the home and PPE stations were well stocked throughout the units. There was good availability of continence products and wipes. However, we observed incontinence pads outside of packaging in various locations throughout the home and wipes were found on top of a clinicalwaste bin. We also observed a bed pan beside a toilet and limited availability of hand paper towels were noted within the Amadeus unit.We identified a number of shower heads that were unclean and on discussion with staff it was identified that there was no system in place for regular shower head cleaning. This was discussed in detail with management and identified as an area for improvement.

On review of staff practices in relation to the management of infection prevention and control (IPC) and COVID-19: GUIDANCE FOR NURSING AND RESIDENTIAL CARE HOMES IN NORTHERN IRELAND, RQIA were concerned that staff were not consistently adhering to appropriate infection prevention and control measures, including the wearing of nail polish, improper use of personal protective equipment (PPE) and missed opportunities for hand hygiene and an area for improvement was identified.

6.2.4 The home's environment

RQIA were concerned that the home had not been maintained in accordance with the regulations and significant areas of the home could not be used by patients. The roof to the Lane unit was mostseverely affectedfollowing a flood and patients were accommodated within other units of the home to facilitate repair works. The dining room within the Amadeus unit had also been affected and was out of bounds to patients resulting in a small lounge area being temporarily used for a dining room. This spacious room would also be used as a social space for the patients with a pool table and other recreational equipment. Its absence significantly reduced their ability to socialise, participate in activities and to enjoy those facilities. It was acknowledged that repair works were underway to bring the room back in to use.

We were concerned regarding the potential for patients to access the dining room in its current state of disrepair as there was damage to the roof and observed building equipment, dust and debris within this room. Toiletries including razors were also identified as accessible to patients within a store in the Amadeus unit and within patients' bedrooms. We brought this to the attention of the registered nurse who agreed to action. Later in the inspection we observed that the store door remained unlocked and were concerned that the necessary action had not been taken to reduce the risk to patients. We discussed the importance of securing the above items to ensure patient safety and an area for improvement was identified.

During the previous inspection on the 9 June 2020 asignificant malodour was evidentwithin an identified area of the home and relevant assurances were received from the management following the inspection that the issue had been addressed.During this inspection the malodour remained evident and was discussed in detail with management as an area for improvement.

A toilet lid had been removed from a toilet and was observed placed behind the cistern.The toilet seat was found to be loose. We further identified a sharp edge to the side of a patient's bedrail which had the potential to cause injury. We shared our concerns with managementand an area for improvement was made.

There was a failure to adequately manage risks to patients within the home in respect of access to hazardous substances/equipment. RQIA identified the door to a store room left open with the potential for patients to access hazardous chemicals. This was identified as an area for improvement.

Food thickening agents were identified unsupervised at various times throughout the Tullybroom House and within a patient's bedroom in the Amadeus unit which had the potential to be consumed by patients. This was an area for improvement which had been identified at the previous inspection and has been stated for a second time.

Medication trolleys were observed to be open and unsupervised on arrival to Tullybroom House. We further identified that the clinical room door within Tullybroom House was also left open and unsupervised with access to medications in unlocked cupboards and a fridge.

This was of particular concern as the patients in the home are unable to independently maintain their own safety and an area for improvement was made.

Significant concerns were also identified in relation to the maintenance checks of the home. On review of the available maintenance records they were poorly maintained. Regular water safety checks were not being completed on the home's plumbing system in accordance with relevant legislative requirements, approved codes of practice and the legionella risk assessment. There was no records available to evidence that regular in-house maintenance checks were being completed in respect of the building; fire equipment, emergency lighting and fire door checks in line with relevant approved codes of practice and as detailed in the fire safety risk assessment and management plan.

We observed a patient seated at the entrance of their bedroom door effectively propping open the door, which was also a designated fire door. A number of other fire doors throughout the home were found to be propped open.These doors would not close properly to prevent the spread of a fire. We further observed a number of fire doors that were unable to close as they were ill-fitting within the door frames. This was an area for improvement at a previous inspection which has been stated for a second time.

Rooms that were being used as stores were cluttered with multiple boxes/itemsand cardboard boxes were identified outside the Lane suite beside the external wall presenting as a potential fire hazard. There was lack of awareness regarding the importance of ensuring that all fire doors are kept clear from obstruction and the inspector requested the registered nurse and manager to review these arrangements. This was identified as an area for improvement.

Fire systems servicing by specialist contractors had not been undertaken during the COVID-19 pandemic reinforcing the need for in-house checks mentioned above. Of particular concern, adequate precautions and systems were not in place to manage fire risk. Staff involved in the maintenance of the premises demonstrated an inadequate knowledge of their roles and responsibilities in relation to risk management. We discussed the importance of implementing immediate monitoring checks on the services within the home and an area for improvement was identified.

Upgrade works to the environment detailed in the 'Urgent Remediation Works' plan submitted to RQIA following inspection in June 2020 had not been sufficiently progressed. Floor coverings were either stained and/or damaged and door frames were chipped to multiple bedroom doors within the Amadeus unit and walls scuffed. This was identified as an area for improvement.

6.2.5 Care delivery

We observed multiple examples of staff not prioritising the dignity of patients. This included the quality and availability of clothing for patients, the potential for socks to be shared amongst patients, lack of curtains in a patient's bedroom, stained and inadequate bedclothes and in one instance a patient was inadequately attired and fully visible to anyone using the car park. A number of bedswithin the Amadeus unit were observed without appropriate bed clothes at 18.15 hours.Furniture within identified patient bedrooms was damaged with multiple drawers not closing effectively. Handles were missing on a number of drawers and/or wardrobes and the hanging rail of an identified wardrobe was missing and the patient's clothing was observed to be untidy and laying at the base of the wardrobe. There was a clear disregard for patients' personal clothing identified in a number of patients' wardrobes. We further observed a patient to be seated in a chair which was leaning to one side due to a coaster missing from the base of

the chair and brought this to the immediate attention of the registered nurse and has since been addressed. Observation of and discussion with staff highlighted their poor recognition of these shortfalls in patient care. These observations were discussed in detail with management and an area for improvement was made.RQIA were concerned that the culture and ethos in the home tolerated this poor standard and showed a disregard for the quality of their home life and experience.

We observedapatient to be unsupervised on a number of occasions within other patient's bedrooms and were concerned that the patient had come into contact with items/equipment within these rooms with the potential risk of contracting and/or spreading the COVID-19 virus. On review of the patients care records it was documented that the patient required enhanced monitoring of their whereabouts. However, the records ofobservational checks were either not completed on identified days or not completed in the agreed time frame. We discussed this matter during feedback and advised that a care management review should be completed to ensure this placement remained suitable for the patient.

In general the home did not provide a therapeutic environment for the patients accommodated. There was a notable lack of effort made to engage patients in any meaningful activity and the activity notice boards were not reflective of the actual activities being provided. Patients were observed in lounges or within their bedrooms with little stimulation. In particular within the Amadeus unit patients were seated in one lounge as the dining room/communal space remained closed leaving little opportunity for social interaction.This was an area for improvement which had been identified at a previous inspection and has been stated for a second time.

We observed the menu on display within the Amadeus unit and Tullybroom House which had not been updated to accurately reflect the date or the meals that had been served during the inspection. This was discussed with management and identified as an area for improvement.

Despite these findings, most patients spoken with indicated that they feltwell looked after by the staff in the Valley Nursing Home.

We also sought resident and relatives' opinion on staffing via questionnaires. There were no responses received.

6.2.6 Care Records

Review of an identified patient'scare records evidenced that this did not reflect the care needs of the patient; supplementary records contained inconsistent and conflicting information with regard to the patient's nutritional care needs and dietary recommendations from the Speech and Language Therapistwhich had the potential to compromise the delivery of safe and effective care. This was discussed in detail with management and identified as an area for improvement.

We observed a patient with a lapstrap whilst seated in their chair. On review of the patient's care plan it was documented that staff must record the duration of time that the lapstrap is on/off as per the frequency agreed within the care plan. We requested records on the monitoring of the lapstrap and were advised by the manager that staff had not completed these records.We further reviewed the seating assessment which had been carried out by an Occupational Therapist (OT) which did not recommend the use of a lapstrap when the patient's chair is stationary. The manager agreed to liaise with the OT to advise them of the use of the lapstrap at

the patient's request and to discuss the importance of record keeping with relevant staff. This was identified as an area for improvement.

Review of four patients' care records evidenced conflicting information in relation to, patient weights, repositioning and catheter care which were not reflective of the needs of the patients. There was no clear system in place to ensure that risk assessments and care plans were reviewed on a regular basis with evidence that several patients' care plans and risk assessments had not been reviewed/updated in several months. Care plans were not person centred to reflect the assessed needs or choices of identified patients as follows:

- care plans for two patients regarding more frequent monitoring of their weight was not being carried out as per the directions within the care plans
- there were inconsistencies in the documentation of the frequency of repositioning, mattress type/setting within supplementary charts and care plans for an identified patient
- there was ineffective management of a patient's urinary catheter
- observational checks for an identified patient were not completed in the agreed time frame as documented within the patient's care plan
- falls risk assessments were not completed for two identified patients who were at risk of falls.

Specific examples were discussed in detail with the manager who acknowledged the shortfalls in the documentation and agreed to communicate with relevant staff the importance of accurately recording such information within patients' care records.This was identified as an area for improvement. RQIA were concerned that similar deficits in recording care had been raised at the inspection on 16 December 2019 and any improvements that had been made had not been sustained.

The above deficits were shared with the SHSCT who advised that relevant support and monitoring of the home would be increased to ensure that identified patients' receive the appropriate care.

Areas for improvement

Nineteennew areas were identified for improvement. These were in relation to: staff induction records; governance audits; monthly monitoring reports; staff duty rota; environmental cleanliness; infection prevention and control; risk management; malodour; fire safety practices; the internal environment; Control of Substances Hazardous to Health compliance; safe storage of medication; maintenance checks; refurbishment of the internal environment; care delivery; menus;nutritional requirements; restrictive practice and care records.

	Regulations	Standards
Total number of areas for improvement	14	5

6.3 Conclusion

Concerns that were raised prior to the inspection were partially substantiated in relation to the availability of hand paper towels; lack of stimulation and availability of meaningful activities anddamage to the internal/external roof in one of the dementia units. These concerns were discussed in detail with management to action as necessary.

RQIA were concerned that there was a lack of regard for patients' safety, dignity and their human rights in relation to respect for their home life.

During the meeting on the 28 October 2020, RQIA did not receive the necessary assurance required and decided to issue a Notice of Proposal (NOP) to cancel the Registration of the Responsible Individual (Healthcare Ireland Belfast Ltd) in respect of Valley Nursing Home.

RQIA informed relevant stakeholders including the Trusts, Health and Social Care Board and the Department of Health following the inspection and continue to liaise with them during this process.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Lorraine Margaret Cozma, manager and Mary Stevenson, regional manager,as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered providershould confirm that these actions have been completed and return the completed QIPvia Web Portalfor assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 21(1) (b)(c) **Stated:** Third and final time **To be completed by:** With immediate effect	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files prior to commencing employment. This relates specifically to ensuring that health checks for staff are completed and that gaps in previous employment are effectively reviewed. Ref: 6.1
	Response by registered person detailing the actions taken: Human Resources audit action plan continues in progression
Area for improvement 2 **Ref:** Regulation 14 (2) (a) and (c) **Stated:**Second time **To be completed by:** With immediate effect	The registered person shall ensure that food thickening agents are stored securely. Ref: 6.1 and 6.2.4
	Response by registered person detailing the actions taken: Staff have been reminded of their responsibilities in this area. Adherence is audited as part of the Home Manager Daily audit.
Area for improvement 3 **Ref:** Regulation 27 (4) **Stated:**Second time **To be completed by:** With immediate effect	The registered person shall ensure that fire doors are maintained to close properly. Ref: 6.1 and 6.2.4
	Response by registered person detailing the actions taken: Fire Doors throughout the Home are closing properly. Staff have been reminded of their responsibility to report any problems urgently to management. Random checks are completed as part of Home Manager's Audit.
Area for improvement 4 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the monthly quality monitoring visit report is robust, that it provides sufficient information on the conduct of the home and that it includes an action plan with timescales to address any deficits identified. Ref: 6.2.1
	Response by registered person detailing the actions taken: Reg 29 reports have been robust and an action plan was in place at end of report with review of previous report within this. It was necessary to carry forward some actions due to the challenges in meeting all actions within one month.

Area for improvement 5 **Ref:** Regulation 27 (2) (d) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the issues identified during this inspection specific to the cleanliness of the environment are urgently addressed. With specific reference to ensuring that: • equipment is stored appropriately • hand paper towels are available within all areas of the home where hand washing takes place • a system is implemented for the regular cleaning of shower heads. Ref: 6.2.3
	Response by registered person detailing the actions taken: Staff have been reminded of their responsibility regarding appropriate storage of equipment. Hand towels were available in hand towel dispensers. Stock of same are re-stocked daily by domestic staff , staff have been reminded regarding their responsibility to re-stock when note stock lower and staff are aware where excess stock is stored. The stock in dispensers is also checked as part of HM Daily Audit. A system is in place for shower head cleaning.
Area for improvement 6 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the infection prevention and control issues identified during this inspection are urgently addressed. With specific reference to ensuring that: • monitoring of staff practices are implemented to ensure they are bare below the elbow and wash their hands at appropriate intervals • staff wear the appropriate PPE in accordance with the task they are completing Ref: 6.2.3
	Response by registered person detailing the actions taken: Infection Control Nurse [SHSCT] has been attending the Home to complete audits of use of PPE and hand washing wth positive results. SHSCT has also delivered refresher training to staff. Adherence to required best practice in these areas is monitored during Daily Home Manager Audit.
Area for improvement 7 **Ref:** Regulation 18 (2) (j) **Stated:** First time	The registered person shall ensure that the malodour in the identified area of the home is investigated and resolved. Ref: 6.2.4

To be completed by: 21 November 2020	**Response by registered person detailing the actions taken:** The malodour has reduced and continues to be investigated
Area for improvement 8 **Ref:**Regulation 14 (2) (a) **Stated:**First time **To be completed by:** With immediate effect	The registered persons shall ensure as far as reasonably practicable that all parts of the home to which patients have access are free from hazards to their safety. Ref: 6.2.4
	Response by registered person detailing the actions taken: Staff have been reminded regarding their responsibilities to maintain safety for residents in regards to hazards. Staff within units have been completing daily audits confirming for example locking of chemical stores and toiletry cabinets and Home Manager validates these during her Daily Home Manager Audit.
Area for improvement 9 **Ref:** Regulation 27 (4) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that: • fire doors are maintained in working order and are not propped open • storage areas are kept tidy and free from obstruction • outdoor storage arrangements are reviewed to ensure that combustible items are not stored beside the home • fire safety systems are maintained in line with legislative requirements, current guidance and good practice. Ref: 6.2.4
	Response by registered person detailing the actions taken: Staff have been reminded regarding not propping fire doors and to keep storage areas tidy and free from obstruction. New bins were organised for cardboard waste and card board is now being stored safely within the allocated bins. Fire safety systems have been reviewed by contractors and remedial works completed. Fire Risk Assessment has been completed 23.11.20 and there are no outstanding actions. Weekly fire alarm checks are up to date.
Area for improvement 10 **Ref:** Regulation 18 (2) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall having regard to the size of the nursing home and the number of patients provide adequate furniture, bedding and other furnishings suitable to meet the needs of the patients. Furniture with surface damage is repaired and/or replaced where necessary. Ref: 6.2.5

	Response by registered person detailing the actions taken: The current residents have furniture, bedding and other furnishings which are fit for purpose and meet needs of resident.
Area for improvement 11 **Ref:**Regulation 14 (2) (a) (c) **Stated:**First time **To be completed by:** With immediate effect	The registered persons must ensure that all chemicals are securely stored in keeping with COSHH legislation to ensure that patients are protected at all times from hazards to their health. Ref: 6.2.4
	Response by registered person detailing the actions taken: All staff have been reminded of their responsibilities in this area. Daily monitoring checks are in place as well as wthin Home Manager Daily Audit to monitor compliance
Area for improvement 12 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that medicines are stored securely at all times. Ref: 6.2.4
	Response by registered person detailing the actions taken: This issue has been addressed with individual nurse involved,and all nurses reminded of their responsibilities in regard to security of medication
Area for improvement 13 **Ref:** Regulation 27(2)(b) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that relevant maintenance checks of the home are maintained in line with legislative requirements. Ref: 6.2.4
	Response by registered person detailing the actions taken: Healthcare Ireland records have been re-instated and compliance is monitored weekly by senior managementb
Area for improvement 14 **Ref:** Regulation 27(2)(b) **Stated:** First time **To be completed by:** 21 November 2020	The registered person shall implement a refurbishment works project, reviewing progress at monthly intervals, and amending scheduled work where necessary. Ref: 6.2.4
	Response by registered person detailing the actions taken: There was a schedule of works for completion but unfortunately this has not been progressed.
Area for improvement 15 **Ref:** Regulation 13 (8) (a) **Stated:** First time **To be completed by:**	The registered person shall make suitable arrangements to ensure that the nursing home is conducted in a manner which respects the privacy and dignity of patients. Ref: 6.2.5

With immediate effect	**Response by registered person detailing the actions taken:** Staff reminded in regard to their responsiblity in regard to assisted dressing with suitable clothing to protect dignity of residents
Area for improvement 16 **Ref:** Regulation 12 (4) (a)(b)(c)(d) & (e) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the effective measures are in place to ensure that the dietary needs of patients requiring a modified diet are safely and effectively met at all times. Ref: 6.2.6
	Response by registered person detailing the actions taken: Information regarding modified diet within care plans, written handover and diet notification records was reviewed to ensure accuracy and consistency Further the dietetic and SALT team from SHSCT also completed a review with Registered Manager for all residents requiring modified diet and fluids
Area for improvement 17 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. Specific reference to care plans, risk assessments and daily records: • care plans must be person centred and relevant to the patients current care needs • risk assessments must be completed where there is a risk of falls and maintained within the patients care records • details of the frequency of repositioning within supplementary recording charts must be reflective of the care plan. Ref: 6.2.6
	Response by registered person detailing the actions taken: A "Resident of the Day" system was put in place with positive outcome in regarding to at least monthly update of risk assessments and care plans. All files were audited to ensure all held all required documents including falls risk assessment. Staff were reminded of importance of contemporaneous recording within all supplementary records including repositioning records and of evidencing care delivery consistent with direction of care plans.
Action required to ensure compliance withthe Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 18	The registered person shall ensure that effective arrangements are in place to ensure that person centred activities are provided to patients in the absence of activities staff being on duty.

Stated: Third and final time **To be completed by:** With immediate effect	Ref: 6.1 **Response by registered person detailing the actions taken:** Activities plans were reviewed to include activities lead by care staff outwith working hours of the Activities Coordinators
Area for improvement 2 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 21 November 2020	The registered person shall ensure that care plans are developed in consultation with the patient to include their preferences. With specific reference to the management of cigarettes. Ref: 6.2 **Response by registered person detailing the actions taken:** The relevant care plans were reviewed evidencing involvement of resident
Area for improvement 3 **Ref**: Standard 35 **Stated:** Second time **To be completed by:** 21 November 2020	The registered person shall ensure that in the absence of the named nurse care plans and risk assessments are reviewed by a competent person. Ref: 6.2 **Response by registered person detailing the actions taken:** " Resident of the Day " system in place and addressed this issue
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 21 November 2020	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • Care records • IPC • Hand hygiene • Environment Ref: 6.2.1 **Response by registered person detailing the actions taken:** Staff involved in auditing were reminded regarding the importance of following through the full circle of auditing process.
Area for improvement 5 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 21 November 2020	The registered person shall ensure the staff duty rota clearly identifies the surname of each staff employee, their role and hours worked; and where amendments are made they are legible and signed. Ref: 6.2.2 **Response by registered person detailing the actions taken:** This was reviewed and senior management checked before off

	duty issued
Area for improvement 6 **Ref**: Standard 39 **Stated:** First time **To be completed by:** 21 November 2020	The registered person shall ensure that newly appointed staff complete a structured orientation and induction and records are retained within the home. Ref: 6.2.2
	Response by registered person detailing the actions taken: This was revisited for all recently employed staff in last 6 months and any shortfalls addressed
Area for improvement 7 **Ref**: Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that a daily menu is displayed in a suitable format and in an appropriate location to reflect the meals on offer. Ref: 6.2.5
	Response by registered person detailing the actions taken: This has been addressed
Area for improvement 8 **Ref**: Standard 18 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in regards to the provision of care to patients who require the use of restrictive practices, specifically the use of a lapstrap: • The seating assessment from the Occupational Therapist should be reflected within the patients care plan • Staff should adhere to the care plan • Staff to document appropriate observational checks of the patient while the restrictive intervention is being used. Ref: 6.2.6
	Response by registered person detailing the actions taken: The occupational therapist updated her assessment to reflect that the lady in question requests that lap strap is used rather than it is required for safety or positioning. Staff complete required document when in use and this is monitored in Daily HM Audit

Please ensure this document is completed in full and returned via Web Portal

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